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SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1941

No. 944

INTER-OCEAN CASUALTY COMPANY,
Petitioner,

vs.

BESSIE BROCKMAN.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE FIFTH CIRCUIT AND BRIEF IN SUPPORT THEREOF.

HARRY SCHERR,
GEO. K. HOLLAND,
Counsel for Petitioner.

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No. 944

INTER-OCEAN CASUALTY COMPANY,
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vs.

BESSIE BROCKMAN.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES CIRCUIT COURT OF APPEALS FOR THE FIFTH CIRCUIT.

The Inter-Ocean Casualty Company prays that a Writ of Certiorari issue to review the judgment of the United States Circuit Court of Appeals for the Fifth Circuit entered on December 1, 1941, affirming the judgment of the United States District Court for the Northern District of Texas, Dallas Division, dated January 23, 1941, for recovery by respondent against petitioner of the sum of $3,374.00, with interest thereon from that date at the rate of 6% per annum, and all costs of suit.

Opinions Below.

The judgment of the District Court is shown in the record at page 17, but that court did not write an opinion. The opinion of the Circuit Court of Appeals is reported in 123 F. (2d) p. 1006.

Jurisdiction.

The judgment of the Circuit Court of Appeals was entered on the first day of December, 1941. The jurisdiction of this Court is invoked under Section 240 (a) of the Judicial Code, as amended by the Act of February 13, 1925 (Section 347, U. S. C. A.).

Summary Statement of the Matter Involved.

Respondent filed this suit October 15, 1940, on policy of accident and health insurance which conditionally provided for monthly indemnity for loss of time. She sued on the accident clauses of the policy, the insuring clause relative to accident being:

> "For loss resulting, without contributing cause, from accidental bodily injuries."

Suit was for indemnity of $100.00 per month for the period September 30, 1938, to date of trial, together with statutory penalties, attorney's fees, and interest.

Respondent alleged she sustained an accidental bodily injury from the lifting of a patient in a hospital on or about September 5, 1938 (R. 2), which injury she alleged to be a rupture of the lumbosacral disc (R. 7); total and continuous disability, but did not allege nor contend it was permanent; regular attendance by a legally qualified physician; proof of loss by giving notice of injury under date of October 4, 1938, and by two letters dated February 10, 1939, and March 30, 1939, respectively, written by Dr. A. R. Thomasson to petitioner, and by a further report accompanied by statement of Dr. O. W. Gibbons, dated May 16, 1939 (R. 3). She did not allege proof of loss for any period of time subsequent to May 16, 1939, but alleged that petitioner denied liability and waived proofs.

Petitioner admitted the receipt of the letters and reports alleged by respondent, but denied these constituted proofs

of loss as required by the policy, and denied that it had waived proofs of loss. It resisted the suit with the plea that there was no accidental bodily injury; that respondent had not complied with the terms and conditions of the policy and had not furnished proofs of loss as required by the policy; that a compliance by insured with the terms and conditions of the policy was a condition precedent to recovery on the policy, and that respondent by virtue of her failure to comply with the terms of the policy, had forfeited her right to indemnity (R. 12-16).

The policy provided for payment of $100.00 indemnity monthly, if the injury within 30 days from date of accident continuously and totally disabled the insured, and if the insured should be regularly attended by a legally qualified physician (R. 9); that the insured should furnish affirmative proofs of loss within 90 days (or within the minimum period allowed by law), after the termination of the period for which the company was liable, and that the indemnity should be payable each thirty days subject to due proofs of loss; that strict compliance on the part of the insured with all the terms and conditions of the policy should be a condition precedent to recovery, and that any failure in that respect should forfeit to the petitioner all rights to any indemnity, and that no waiver of any of its provisions shall be valid unless agreed to in writing by an executive officer of the company and attached to or endorsed on the policy (R. 10, 22).

On trial of the cause the only evidence offered on the question of whether the alleged injury was accidental, was respondent's testimony that while she was lifting an anaesthetic patient from a hospital carriage to a bed she had a severe pain in her back which ran down into her leg and that she had difficulty straightening up (R. 55), and that the patient was too large for them to lift (R. 70), and that she had heard of other people hurting their backs (R. 63).

No evidence was offered to show anything unforeseen, unexpected, and unusual that accompanied the voluntary act of respondent and produced the alleged injury.

There was no positive evidence of rupture of the disc, but only evidence for a speculation and conjecture. There is no basis for presumption of rupture, but there is evidence affording a reasonable presumption that no rupture could have occurred under the circumstances.

Only two proofs of loss were furnished by respondent, dated October 4, 1938, and May 16, 1939, respectively. These related to the claimed accident. Other proof forms for reporting accidental injury disability and for reporting illness disability were furnished respondent, but they were not completed and returned to petitioner. No proofs of loss were furnished for any period subsequent to May 16, 1939, but recovery was allowed to December 30, 1940.

For the purpose of showing waiver of proofs of loss, respondent introduced in evidence letters written by petitioner to respondent (R. 79-82, 84, 86, 90, 94).

The court charged the jury that "accidental injury is an unintended result of an intended act (R. 134). Petitioner excepted to the charge but the court overruled the exception (R. 138). Petitioner requested the court to charge the jury that "if the injury followed in a usual or reasonably to be expected way from the means voluntarily employed, that is, the given voluntary act, it is not a result accidentally effected" (R. 138). The court refused to give the requested charge.

The cause was tried on January 22, 1941, resulting in a verdict in favor of respondent for 27 months disability (R. 17), and judgment, dated January 23, 1941, against petitioner for the sum of $3,374.00, with 6% interest from that date.

Petitioner's motion for directed verdict was overruled (R. 16, 132), as was also its motion for judgment notwith-

standing the verdict, and, in the alternative, for a new trial (R. 18, 21).

Upon appeal the cause was submitted in the Circuit Court of Appeals November 11, 1941, which court on December 1, 1941, affirmed the trial court's judgment. Petition for rehearing was duly filed on December 20, 1942, but was overruled January 12, 1942, without written opinion. Motion for stay of mandate was filed in the Circuit Court of Appeals on January —, 1942, and was granted January 19, 1942.

Questions Presented.

1. Is proof of injury alone, without proof that something unforeseen, unexpected and unusual accompanied the voluntary act of respondent and produced the alleged injury, sufficient to show accidental bodily injury within the meaning and intent of the policy provision?

2. Without direct, positive evidence of a ruptured disc, and no basis for a legal presumption to be indulged that there was a rupture, the respondent having alleged a rupture of the disc as a basis for her claim for indemnity, did respondent meet the burden of proof so as to give support for verdict and judgment?

3. Liability for indemnity is predicated on proof of disability and loss resulting from accidental bodily injury, and claim for indemnity is based on alleged accidental injury from a voluntary act of claimant. On the issue of accidental bodily injury the court charged the jury as follows:

> "I charge you that accidental injury is an unintended result of an intended act. In order to make it applicable to this particular condition here, that is, she claims that she was assisting in the removal of the patient from the carriage to the patient's bed, and while in that act that she hurt her back. You see, she intended to move the patient, she did not intend to have

> it hurt her back. That is an intended act accompanied by an unintended result" (R. 134).

Petitioner excepted to the charge, but the court overruled the exception (R. 138). Petitioner requested that the court charge, in substance at least, as follows:

> "If the injury followed in a usual or reasonably to be expected way from the means voluntarily employed, that is, the given voluntary act, it is not a result accidentally effected" (R. 138),

but the request was refused (R. 138).

Respondent had testified that she had heard of other people getting their backs hurt, and that the patient was too large to lift.

The question is whether the court should have charged the jury as requested by petitioner.

4. The insurer furnished form for making proof of loss for accident disability, which was sent in October 10, 1938, but not completed with full information requested. November 29, 1938, insurer furnished insured with additional form for proof of accident disability, requesting its completion and offering to pay accrued indemnity upon completion of proof, but insured did not complete or return it. February 13, 1939, insurer furnished insured with another form but insured did not complete and return it, and on February 25, 1939, insurer, because it considered the claim as one for illness disability, and so advised the insured, furnished the insured with form for proof of illness disability, which insured and her doctor refused to complete and return. March 25, 1939, insurer explained why it had furnished form for proof of illness and stated it would be glad to make adjustment of claim upon submission of necessary proof, and sent another illness form, which insured refused to complete and return. April 11, 1939, insurer sent draft for a period of disability and another illness proof form. April 17, 1939, insured's attorney made de-

mand that insured be paid the sum of $100.00 per month, each and every month, as provided in the policy. On April 19, 1939, insurer furnished insured with another form for proof of accident disability, and on May 8, 1939, wrote insured's attorney regarding the completion of that form and suggested that if insured desired the accrued benefits paid at that time, to please complete the proof. The form was filled in and returned to insurer on May 17, 1939, who on May 22, 1939, requested insured to send insurer a quotation of Section 2, Part "A" of the policy, upon receipt of which insurer would give definite answer as to liability. Insured did not comply with this request but filed suit in the State court (later dismissed), where by deposition taken by insured, insurer's Claim Manager contended the claim should be under the illness clauses of the policy, and said that the claim would be paid under those clauses upon completion of proof (R. 74-98, 124-128).

The question is, whether under these circumstances insurer repudiated the contract.

5. The policy provides for monthly accident indemnity, subject to insured's furnishing affirmative and due proofs of loss showing continued disability. It provides that such proofs are a condition precedent to liability, and must be furnished within 90 days (or within the minimum period allowed by law) after the termination of the period for which insurer is liable. There was no contention and no evidence that the alleged disability was permanent. The insured executed and sent to insurer only two proof of loss forms, the first dated October 4, 1938, and the last dated May 16, 1939, but recovery was allowed for the periods from May 16, 1939, to December 30, 1940. Since petitioner's liability for indemnity arises only on performance by respondent of the condition precedent that she furnish petitioner with affirmative and due proofs of loss, and since she failed to furnish such proofs for any period

subsequent to May 16, 1939, the question is whether recovery could be had for the periods from May 16, 1939, to December 30, 1940.

Reasons Relied On for Allowance of the Writ.

1. The Circuit Court of Appeals has decided important questions of law contrary to the general principles of law and in such a way as to conflict with the applicable local decisions, as well as with decisions of other Circuit Courts of Appeals and of the United States Supreme Court.

2. The Circuit Court of Appeals has so far departed from the accepted and usual course of judicial proceedings, or has so far sanctioned a departure by the trial court, as to call for an exercise of this Court's power of supervision. The decision is without evidence to support it, and it disregards valid and subsisting terms and conditions of the contract, allowing a recovery without right thereto and contrary to the contract.

3. The Circuit Court of Appeals has held in this cause that under an insurance policy providing for indemnity on account of disability from accidental bodily injury, proof of injury alone is sufficient to show that there was an accident, and that it is unnecessary to prove the existence of anything unforeseen, unusual and unexpected, accompanying the voluntary act of the injured person, that produced the injury.

We believe this holding is in conflict with that of this Court in *Mutual Accident Association* v. *Barry,* 131 U. S. 100, and also with the holding of the Circuit Court of Appeals, 9th Circuit, in the case of *Aetna Life Insurance Company* v. *Portland Gas & Coke Company,* 229 F. (1) 552, and *New York Life Insurance Company* v. *Ollich,* 42 F. (2) 399, Circuit Court of Appeals, 6th Circuit. It is also in conflict with the holding of the Supreme Court of Texas in the case of *Bryant* v. *Continental Casualty Company,* 182 S. W.

(1) 673, and the case of *International Travelers Association* v. *Francis,* 23 S. W. (2) 282.

4. The decision of the Circuit Court of Appeals is in conflict with the universal holding of courts that a verdict and judgment must be supported by the evidence, in that the court affirmed the judgment of the trial court though there was no evidence that the alleged injury was accidental, and none of a ruptured disc.

5. The decision of the Circuit Court of Appeals in this cause is contrary to the general principles of law governing charges to the jury in the trial of cases involving the issue of accidental bodily injury, in that it affirmed the trial court in its charge to the jury that accidental injury is an unintended result of an intended act, and affirmed the trial court's refusal to charge the jury, at the request of petitioner, that if the injury followed in a usual or reasonably to be expected way from the means voluntarily employed, that is, the given voluntary act, it is not a result accidentally effected.

The requested charge is the law as declared and held by the Supreme Court of Texas. *Bryant* v. *Continental Casualty Company,* 182 S. W. (1) 673; *International Travelers Association* v. *Francis,* 23 S. W. (2) 282. In the case at bar there was testimony which, if true, shows the claimed injury from the voluntary act of respondent in lifting the patient followed in a usual or reasonably to be expected way and was the natural and probable consequence of the voluntary act.

6. The decision of the Circuit Court of Appeals in this cause is in conflict with the decisions of this Court in the case of *Mobley* v. *New York Life Insurance Company,* 295 U. S. 632, and *New York Life Insurance Company,* v. *Viglas,* 297 U. S. 672, and the decision of the Circuit Court of Appeals, Fifth Circuit, in the case of *Mobley* v. *New York*

Life Insurance Company, 74 F. (2) 558, and the decision of the Circuit Court of Appeals, Tenth Circuit in *Kimel, et al.* v. *Missouri State Life Insurance Company*, 71 F. (2) 921, and with applicable Texas decisions, on the question of whether under the facts in this cause there was a repudiation of the contract by petitioner.

7. The decision of the Circuit Court of Appeals is in conflict with decisions of this Court, and Circuit Courts of Appeals, and applicable local decisions, on the question of whether recovery may be had for the periods of alleged disability from May 16, 1939, to December 30, 1940, for which no proofs of disability were furnished, though required as a condition precedent to liability.

8. The decision of the Circuit Court of Appeals has made erroneous findings of fact, and has erroneously construed the legal effect of the evidence, and has disregarded valid and subsisting terms and conditions of the policy sued on, and has failed to apply the rules of law as pronounced by local decisions and decisions of this Court applicable to the facts in this cause.

Conclusion.

Wherefore, we respectfully submit that this petition for a writ of certiorari to review the judgment of the Circuit Court of Appeals for the Fifth Circuit should be granted.

Dated January 31, 1942.

HARRY SCHERR,
First Huntington National Bank Building,
Huntington, West Virginia;
and
GEO. K. HOLLAND,
1612 Kirby Building,
Dallas, Texas,
Of Counsel for Petitioner.

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1941

No. 944

INTER-OCEAN CASUALTY COMPANY,

Petitioner,

vs.

BESSIE BROCKMAN.

BRIEF IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI.

To the Honorables, the Chief Justice and Associate Justices of the Supreme Court of the United States:

Opinions Below.

The judgment of the District Court is shown in the record at page 17, but that court did not write an opinion. The opinion of the Circuit Court of Appeals is reported in 23 F. (2), page 1006.

Jurisdiction.

The judgment of the Circuit Court of Appeals was entered on the first day of December, 1941. The jurisdiction of this Court is invoked under Section 240 (a) of the Judicial Code, as mentioned by the Act of February 13, 1925 (Section 347 U. S. C. A.).

Statement of the Case.

In the petition for the writ there is set out a statement of the case, and it is deemed not required to repeat that statement here. We assume the court will make needed reference thereto. There will be added in this brief, in appropriate places, such additional material matters as are necessary for a proper consideration of the questions presented, with appropriate page references to the printed record.

Specifications of Error.

The following specified errors are intended to be urged herein. They are a part of the errors specified in petition for rehearing in the Circuit Court of Appeals (R. 151-161).

I.

The Circuit Court of Appeals erred in holding that accidental bodily injury is sufficiently proved by evidence only of injury, and that it is unnecessary to prove the existence of something unforeseen, unexpected and unusual which accompanied the voluntary act and produced the injury.

II.

The Circuit Court of Appeals erred in holding that there was evidence that appellee sustained a rupture of her lumbosacral disc.

III.

The Circuit Court of Appeals erred in failing to hold that the charge of the trial court, on the issue of accidental bodily injury, was erroneous in that it failed to include an instruction to the jury, in substance at least, that if the injury followed in a usual or reasonably to be expected way, from the means voluntarily employed, that is, the given voluntary act, it is not a result accidentally effected.

IV.

The Circuit Court of Appeals erred in holding that the charge to the jury on the issue of accidental bodily injury, as follows:

> "I charge you that accidental injury is an unintended result of an intended act. In order to make it applicable to this particular contention here, that is, she claims that she was assisting in the removal of a patient from the carriage to the patient's bed, and while in that act, that she hurt her back. You see, she intended to move the patient, she did not intend to have it hurt her back. That is an intended act accompanied by an unintended result",

is a sufficient charge and instruction on the issue, and that it was unnecessary to further charge that "if the injury followed in a usual or reasonably to be expected way, from the means voluntarily employed, that is, the given voluntary act, it is not a result accidently effected."

V.

The Circuit Court of Appeals erred in holding, on p. 3 in its opinion, that appellee had complied with the policy terms requiring her to furnish proofs of loss.

VI.

The Circuit Court of Appeals erred in its holding that appellant waived proofs of loss.

VII.

The Circuit Court of Appeals erred in holding that appellee, without furnishing appellant proofs of loss for periods subsequent to May 16, 1939, is entitled to recover indemnity for such periods.

VIII.

The Circuit Court of Appeals erred in failing to hold, as a matter of law, that appellant was entitled, under the terms of the policy, to proofs of loss each thirty days during which liability might continue, and that since appellee failed to furnish such proofs of loss she would not be entitled to recover for the periods for which no proofs were made.

ARGUMENT.

On First Question Presented.

The policy clause insuring against disability from injury limits the risk to accidental bodily injury (R. 9, 22). Respondent alleged she sustained accidental bodily injury from the lifting of a patient in a hospital (R. 2). The issue thus raised is that there was something accidental in the act of lifting. The only evidence offered on the issue was the testimony of respondent, which was that she lifted an anaesthetic patient and had a severe pain in her back, which ran down into her leg, and that she had difficulty straightening up (R. 55), and that the patient was too large for them to lift (R. 70), and that she had heard of others getting their backs hurt (R. 63).

The contention of petitioner is that the evidence does not show accidental injury, and that proof of injury alone is not sufficient to show accident; that it is necessary to show something unusual, unforeseen and unexpected accompanied the act of lifting and produced the injury,—that the injury followed in an unusual and not to be expected way, and therefore was not the natural and probable consequence of the act.

The act of lifting, as such, is a normal and ordinary physical activity. The evidence does not show anything unusual, unforeseen and unexpected in the act of lifting

the patient. If the patient was too large for them to lift, as she testified, she was forewarned of a probable and reasonably to be expected injury from the act.

The policy does not insure against all injury, but only against accidental injury. To say that proof of injury alone is sufficient to show it was accidental, is to eliminate from the policy provision the word that limits the risk assumed. The word "accidental" was intended to describe an injury that is not the usual and reasonably to be expected result of a voluntary act,—an injury where there is something unusual, unforeseen and unexpected in connection with the voluntary act that produces an unnatural and improbable consequence of the act.

We believe the weight of authority supports the contention of petitioner herein for the requirements of proof of accident and of accidental injury.

Mutual Accident Assn. v. *Barry,* 131 U. S. 100;

Bryant v. *Continental Casualty Company,* 182 S. W. (1) 673; and

International Travelers Association v. *Francis,* 23 S. W. (2) 282.

In the case last cited the court defines "accident" and "accidental" as follows:

> "An effect which is the natural and probable consequence of an act or course of action is not an accident, nor is it produced by accidental means. It is either the result of actual design, or it falls under the maxim that every man must be held to intend the natural and probable consequence of his deeds".

The cases of *Aetna Life Insurance Company* v. *Portland Gas & Coke Company,* 229 F. (1) 552, Ninth Circuit, and *New York Life Insurance Company* v. *Ollich,* 42 F. (2) 399, Sixth Circuit, support the contention of petitioner as hereinabove stated.

Respondent offered no evidence of anything unforeseen, unexpected and unusual accompanying her act and producing injury, or that the injury followed in an unusual and not to be expected way and was not the natural and probable consequence of her act. Nothing was shown that could possibly have produced the alleged injury, unless it was the largeness of the patient. But she foresaw this condition and must be held to have comprehended, and to have reasonably expected that the natural and probable consequence of her act would be injury. Under the rule quoted above, respondent did not prove accidental injury.

To hold that proof of injury alone is sufficient to show that it was an accident, will remove the burden of proof on a claimant to show that his injury was accidental, and will place upon the insurer the burden of showing that the injury was not accidental. It will remove from the policy contract the special word placed there for the purpose of limiting the risk so as not to include general injuries not having the elements of accident in connection with them.

On Second Question Presented.

The second question presented is based upon the absence of any positive evidence of a ruptured disc and the absence of any evidence to support a legal presumption of rupture. Respondent did not testify there was a rupture, as is disclosed by referred to portions of her testimony hereinabove. Neither of her medical experts testified positively there was a rupture; in fact, Dr. Williams testified he did not know what the condition of the disc was (R. 39), and Dr. Thomasson stated he did not know whether there was a rupture (R. 53). Each of the doctors based a diagnosis of rupture on symptoms only, which symptoms were also indicative of diseased conditions (R. 39-53). Each of the doctors testified that the disc was so tough that it would require

tremendous pressure to cause a rupture (R. 36-52), but neither of them testified as to how much weight lifted would be necessary to rupture a disc, and there is no evidence of what that weight would be and no evidence of what was the weight lifted by respondent on the occasion in question. On the other hand, there was positive and direct evidence that in lifting a patient from a carriage to a bed four persons participated in such way as to at least equalize the weight lifted, and in such manner that no stooping or unusual posture would be required in the act of lifting (R. 120-122).

The evidence was insufficient to do more than create a surmise or supposition of rupture. That is not enough to support the verdict and judgment.

Altmayer v. *Travelers Protective Ass'n. of America*, 119 F. (2) 1005, 7th Circuit.

On Third Question Presented.

The question here presented is in regard to the court's charge to the jury on the issue of accidental bodily injury. The charge was that accidental injury is an unintended result of an intended act (R. 134). Respondent excepted to this charge and requested that the jury be charged, in substance at least, that if the injury followed in a usual or reasonably to be expected way from the means voluntarily employed, that is, the given voluntary act, it is not a result accidentally effected (R. 138). The respondent had testified that the patient she lifted was too large to lift (R. 70), and that she had heard of other people getting their backs hurt (R. 63).

The court's charge limited the definition of injury to an unintended result of a voluntary act. That definition and instruction is too restricted, and is inconsistent with the definition of accidental injury as determined by the Supreme Court of Texas in the case of *International Travel-*

ers Association v. *Francis*, 23 S. W. (2) 282. Petitioner's requested charge was in thorough accord with the holding in the *Francis* case, and in the case of *Bryant* v. *Continental Casualty Company*, hereinbefore cited. The court's charge amounted practically to an instruction for the jury to find for respondent, because the charge failed to call to the jury's attention, as a part of the definition of accident or accidental injury, that there must be something unusual, unforeseen and unexpected in connection with the voluntary act, and that if the injury was a natural and probable consequence of the voluntary act it would not be an accident nor accidental. The respondent having testified that the patient was too large for them to lift, and that she had heard of others getting their backs hurt, gave ample support to the request of petitioner that the jury be charged as indicated by petitioner, for from such evidence the jury would have been entitled to have inferred and found that the claimed injury was the natural and probable consequence of a voluntary act, and that there was nothing unusual, unforeseen and unexpected in connection with the act of lifting and therefore that the injury was not accidental.

The trial court's definition of accidental injury, limited as it is, to whether the claimant intended to be injured, fails altogether to recognize the elements of accident that must exist before there is accidental injury, and it removes from the claimant the burden of proving the facts necessary to constitute accidental injury, and places upon the insurer the burden of showing there was no accident. The charge is such as to permit a claimant to establish his case by simply testifying that he was hurt and that he did not intend to be hurt. Claimant's "intention" could hardly be disproved, for it is a condition which can be determined only by the claimant's mental attitude, and claimant alone is in possession of that fact.

The charge requested by petitioner was proper and necessary for the protection of its legal rights, and the court's failure to give the charge deprived petitioner of a fair and just trial before the jury.

On the Fourth Question Presented.

The fourth question presented is whether under the facts in this cause the insurer repudiated the contract. The policy sued on afforded coverage for disability from accidental bodily injury or illness. The indemnity provided was $100.00 monthly for total and continuous disability on account of accidental injury (R. 9), subject to affirmative and due proofs of loss to be filed within 90 days (or the minimum time required by law) after termination of the period for which insurer should be liable (R. 10). The policy made the furnishing by insured of proofs of loss a condition precedent to the right of recovery under the policy (R. 10), and provided that no waiver of the terms of the policy should be valid unless made by an executive officer of the company and endorsed in writing on the policy (R. 10).

Petitioner furnished respondent with forms for making proofs of loss on account of accident disability, and illness disability, as disclosed by correspondence from petitioner to respondent (R. 79, 82, 84, 86, 90, 94). The facts in connection with the furnishing of proofs of loss forms by petitioner to respondent and the action of respondent in regard to such proofs of loss forms, and as to the attitude and efforts of petitioner in regard to its liability under the policy contract, are shown by the letters written by petitioner to the respondent, hereinabove referred to, and all the facts are set out in Question Number 4 in the petition for writ of certiorari, to all of which the court is respectfully referred, to avoid repetition here. Do the facts constitute a repudiation of the contract?

The facts show, at most, only a controversy between petitioner and respondent as to whether proofs of loss and payment of indemnity should be made on account of accident disability or illness disability. There was never a denial of liability, and no refusal to pay. The correspondence between respondent and petitioner clearly shows that petitioner sought to obtain proofs of loss for either accident or illness disability, and expressed a willingness to make payment of indemnity upon completion of proof. When respondent refused to furnish illness disability proofs, petitioner furnished another accident disability proof form, again offering to pay indemnity, and requested completion of proof. The facts show that petitioner was attempting to determine the matter of what sort of liability it had on the contract. The controversy with respondent was only an attempt to settle divergent views. Petitioner did not assume the position that it did not owe indemnity under the contract, but only asserted that as it understood the facts its liability was under the illness clauses instead of the accident clauses of the policy.

Not only was there no repudiation of the contract by petitioner, but there was not even a partial breach, for petitioner recognized that possibly it owed respondent some indemnity and offered to pay it upon proof of disability. There is no repudiation of a contract unless there is a definite and unqualified denial of all liability and refusal to perform. As long as there is recognition of some obligation under a contract, there is no repudiation.

In *New York Life Insurance Company* v. *Viglas,* 297 U. S. 672, Viglas made claim against the company for indemnity on account of total and permanent disability, and after the company had recognized its liability for payment and had made payment for several months, it concluded the

disability had ceased and refused to make further payments. Thereafter it declared the policy lapsed. In his suit Viglas alleged the facts above stated and claimed they constituted a repudiation of the entire contract, relieving him of any further obligation. In disposing of the case this Court held:

> "Upon the showing made in the complaint there was neither a repudiation of the policy nor such a breach of its provisions as to make conditional and future benefits the measure of recovery. Repudiation there was not, as the term is known to the law. Petitioner did not disclaim the intention or the duty to shape its conduct in accordance with the provisions of the contract. Far from repudiating those provisions, it appealed to their authority and endeavored to apply them. * * * There is nothing to show that the insurer was not acting in good faith in giving notice of its contention that the disability was over. If it made a mistake there was a breach of a provision of the policy with liability for any damages appropriate thereto. We do not pause at the moment to fix the proper measure. Enough in this connection that at that stage of the transaction there had been no renunciation or abandonment of the contract as a whole."

In *Mobley* v. *New York Life Insurance Company*, 74 F. (2) 588, Fifth Circuit, the Court held:

> "In order to constitute an anticipatory breach of the entire contract there must be a clear and unequivocal repudiation by the promisor of all that remains to be performed, a refusal to be further bound by the contract * * * All that happened was that the company misjudged its obligations. Such an error made in good faith, whether founded in mistake of law or fact, is not repudiation, and does not end a continuing contract, but calls only for its enforcement according to its terms."

In *Kimel* v. *Missouri State Life Insurance Company,* 71 F. (2) 921, Tenth Circuit, the court held in effect that a promisor's renunciation must be clear and unequivocal, and refusal to perform must be of whole contract.

In *Universal Life & Accident Insurance Company* v. *Sanders,* 102 S. W. (2) 405, the Supreme Court of Texas held:

> "It is not to be understood that we are extending the doctrine of anticipatory breach so as to make it applicable to cases where the insurer merely denies liability or claims defenses under the terms of the policy. The Pollack opinions limit its application to cases in which the obligor absolutely repudiates the obligation without just excuse."

In *Provident Savings Life Assurance Society* v. *Ellinger,* 164 S. W. (1) 1024, the Texas Court of Civil Appeals at Austin held:

> "When an anticipatory breach of a contract is intended to be shown by the declaration of the party that he will not perform the same, such declaration must be in positive and unconditional terms."

In *Senter* v. *Dixie Motor Coach Corporation,* 67 S. W. (2) 345, the Texas Court of Civil Appeals at Dallas, held:

> "The positive refusal to perform a contract is certainly a breach of it, but the mere assertion of a party that he will not perform an executory contract is not in itself sufficient to constitute a breach, nor will a controversy over the terms of a contract and the extent of damage to the subject matter, or the construction to be placed upon them, be deemed such a renunciation or abandonment as will authorize the other party to treat the contract as breached."

The facts in the case at bar, we submit, clearly show there was no repudiation of the contract and no breach of

any of its provisions by the insurer, and we further submit that the authorities next above quoted support petitioner's contention that it did not repudiate or breach the contract.

On the Fifth Question Presented.

This question is in regard to whether recovery could be had for the monthly periods from May 16, 1939, to December 30, 1940. If there was no repudiation of the contract by petitioner, as we think we have demonstrated under the fourth question, then under the terms and conditions of the policy respondent was duty bound to furnish to petitioner proofs of continued disability, for the periods May 16, 1939, to December 30, 1940, which proofs were a condition precedent to liability under the policy; and since she failed to furnish such proofs, she would have no right or cause of action for indemnity for those periods and no recovery could be had therefor. If, however, it should be held that there was a repudiation by petitioner of the contract, then respondent's rights and remedies are to be determined by her election and treatment of the contract, and the rights given her under the law.

If the contract was repudiated by petitioner, respondent had the right to treat the contract as ended at the time of its repudiation and then sue for damages for the breach thereof, or, should she choose to do so, she might treat the contract as not ended but continuing in force and effect, and require performance. Had she treated the contract as ended, her claim for damages for the breach could have been presented, but the damages would have been limited as of time of breach. Under the contract in question her damages would have been the amount of indemnity payable for the past and current periods of proven disability. No damage could have been claimed for future monthly periods,

because the claimed disability was not permanent but temporary, and there could have been no definite ascertainment of future periods of disability and amount of indemnity except on the basis of speculation and supposition.

It appears that respondent contends the contract was repudiated, but treats it not as ended but as continuing. She thus elected to treat the contract as if there had been no repudiation. This attitude of respondent and treatment of the contract continued the burdens and duties, if any, upon petitioner to perform its part of the contract according to the terms and conditions thereof, and continued the burdens and duties upon respondent to perform her duties and obligations under the contract according to its terms and conditions.

In the case of *Greenwell Theatrical Circuit* v. *Markowitz*, 79 S. W. (1) 1069 (loc. p. 1071), the Supreme Court of Texas held:

> "The promisee, if he pleases, may treat the notice of intention as inoperative, and await the time when the contract is to be executed, and then hold the other party responsible for all the consequences of nonperformance; but in that case he keeps the contract alive for the benefit of the other party as well as his own. He remains subject to all his own obligations and liabilities under it, and enables the other party not only to complete the contract, if so advised, notwithstanding his previous repudiation of it, but also to take advantage of any supervening circumstance which would justify him in declining to complete it."

The case of *Wellington Railroad Committee* v. *Crawford*, 216 S. W. (1) 151, by the Texas Supreme Court, is to the same effect as the *Markowitz* case.

Under the terms and conditions of the policy respondent was definitely obligated to furnish affirmative and due

proofs of loss, as a condition precedent to liability of petitioner, and for recovery of indemnity (R. 10, 22). The policy provided that the indemnity should accrue and be payable monthly (R. 9, 10), and respondent demanded monthly payments (R. 78, 89). Proofs of disability under the policy provisions were required to be furnished not later than 90 days (or the minimum period provided by law) from the termination of the period of liability.

Since respondent elected to treat the contract as continuing in force and effect, she had the duty of complying with its terms and conditions, and to furnish proofs of disability as above stated. In *Metropolitan Life Insurance Company* v. *Wann,* 109 S. W. (2) 470, the Supreme Court of Texas held:

> "By the terms of the policy, the filing of proof showing that the insured was totally and permanently disabled was a condition precedent to recovery. When a policy contains such provision, and the proof fails to establish that the insured has complied therewith, no right of recovery is shown."

She did not allege that she had furnished such proofs for the periods subsequent to May 16, 1939, and no evidence was offered by her to show that such proofs had been tendered. There was therefore a failure on her part to comply with the terms and conditions of the policy.

Southern Surety Company v. *Aronson,* 5 S. W. (2) 629; By Court of Civil Appeals of Texas, at Galveston;

State Life Insurance Company of Indianapolis, Ind. v. *Parks,* 89 S. W. (2) 289; By Court of Civil Appeals of Texas, at Amarillo.

Respondent attempts to justify her failure to comply with the terms and conditions of the contract by alleging

that petitioner waived such compliance. But there was no evidence of any waiver of proofs of loss for any period. All the correspondence from petitioner to respondent insisted upon compliance with the terms and conditions of the policy, and shows an endeavor on the part of petitioner to obtain from respondent proofs of loss. Respondent endeavors to show from such correspondence a waiver of proofs of loss; but even if such correspondence showed a waiver it would be applicable solely to past periods or the current period of disability, and under no circumstances could apply to conditional future periods, for the reason that the claimed injury and disability of respondent was not alleged nor shown to be permanent, but only temporary, and the conditions in periods subsequent to May 16, 1939, were not determined, and remained uncertain and unknown at the time of the alleged waiver. A waiver exists only where there is a present known right which can be waived.

Garvey v. *Blatchford Calf Meal Co.*, 119 F. (2) 973, 7th Circuit.

The matter of disability and its degree, for future periods, was not determined nor definitely ascertainable at the time of the claimed waiver. Certainly, petitioner did not know what the disability and its degree, if any, would be in the future. Unless disability should continue to be total there would be no liability after twelve months from date of injury, for the policy so provides (R. 9). There was no duty under the policy for respondent to furnish proofs of disability prior to the period for which proof should be made, nor did petitioner have any right to require the filing of a proof of disability for future periods. Therefore, there was no right that could be waived, and there could have been no waiver on May 16, 1939, or prior thereto, of proofs of disability for future periods.

Conclusion.

We submit that this case calls for the exercise by this Court of its supervisory power by granting a Writ of Certiorari for review, and revision of the judgment of the Circuit Court of Appeals.

Respectfully submitted,

HARRY SCHERR,
First Huntington National Bank Bldg.,
Huntington, West Virginia;
and
GEO. K. HOLLAND,
1612 Kirby Building,
Dallas, Texas,
Of Counsel for Petitioner.

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